5 Montes

PRINTED: 12/20/2007 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD12-0054 12/06/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1490 BANGOR ST. SE **AZURE** WASHINGTON, DC 20020 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFIÇIENÇY) 1000 INITIAL COMMENTS 1000 A re-licensure survey was conducted from December 5, 2007 through December 6, 2007. A random sample of three residents was selected from a residential population of five males with mental retardation and other disabilities. The survey findings were based on observations in the group home, interviews and review of records, including unusual incident reports. 1 041 3502.2(a) MEAL SERVICE / DINING AREAS 1041 3502.2 (a) 174/08 The physician will provide a Modified diets shall be as follows: prescription of the current diet order of resident #1 and resident #2. In the (a) Prescribed in the resident's Individual future the nursing coordinator will Habilitation Plan and the record of the prescription for the modified diet shall be kept in ensure that the current diet orders are the resident 's record; received and filed in the residents chart. This Statute is not met as evidenced by: Based on staff interview and record review, the Group Home for persons with Mental Retardation (GHMRP) failed to ensure the implementation of resident's modified food texture for two of the three residents in the sample. [Residents #1 and #2] The findings include: The facility failed to ensure residents received their meals in a modified texture as recommended as evidenced below: Interview with the direct care staff on December 5, 2007 revealed that they were not familiar with Residents #1 and #2's diets. Review of the records on the aforementioned date revealed Residents #1 and #2 had Individual Support Plans (ISP) dated March 22, 2007 and February 5, 2007 respectively. gulation/Administration LIER REPRESENTATIVE'S SIGNATURE OR'S OR PROVIDED STI

Smith

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING HFD12-0054 12/06/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1490 BANGOR ST. SE AZURE WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) 1041 Continued From page 1 1041 Further review of Resident #1's record revealed a Nutritional Assessment dated August 27, 2007. According to the assessment, Resident #1 had a recommendation for a 2000 calorie diet/weight loss/4 gram sodium diet with a goal to reduce it to 1800 calorie diet /weight loss/4 gram sodium diet. At the time of the survey, there was no documented evidence of a prescription for the recommended diet order. According to Resident #2's "Mealtime Supports he had a low cholesterol diet. Further review of Resident #2's record revealed a Nutritional Assessment dated March 20, 2007. The plan recommended from the assessment was to encourage the resident to eat low sodium, low fat, foods. At the time of the survey, there was no documented evidence of a prescription for the recommended diet order. 1 043 3502.2(c) MEAL SERVICE / DINING AREAS 1043 Modified diets shall be as follows: 3502.2 (c) 1/12/08 A new nutritionist was hired on (c) Reviewed at least quarterly by a dietitian. 12/7/07 and will complete the necessary quarterly assessments for This Statute is not met as evidenced by: resident #1 and resident #2 Based on interview and record review, the Group Home for persons with Mental Retardation (GHMRP) failed to ensure that two of the three residents with modified diets had been reviewed at least quarterly by the consulting dietitian. (Residents #1 and #2) The finding includes: Review of Resident #1's record revealed a Nutritional Assessment dated August 27, 2007. Health Regulation Administration

STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA IMBER;	(X2) MUI A. BUILD B. WING		(X3) DATE COMP	SURVEY PLETED
NAME OF F	PROVIDER OR SUPPLIER	HFD12-0054			12	/06/2007	
AZURE	-ROVIDER OR SUPPLIER		STREET ADDRESS, CITY 1490 BANGOR ST, S WASHINGTON, DC		SE		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FILL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLE DATE
1 043	Continued From pag	je 2		1 043		<u> </u>	-
	According to the ass recommendation for loss/4 gram sodium 1800 calorie diet /we Further review of Re that a nutritionist rev 20, 2007. At the time failed to show evider nutritionist had review diet plan at least quarticon	a 2000 calorie diet/ diet with a goal to re eight loss/4 gram soc sident #1's records iewed his diet plan c e of the survey, the nce that a dietitian or wed Resident #1's re	weight educe it to dium diet, revealed on March GHMRP				
1	According to Resider he had a low choleste Resident #2's record Assessment dated M from the assessment resident to eat low so time of the survey, the evidence that a dietitireviewed Resident #2 quarterly.	erol diet. Further revealed a Nutrition arch 20, 2007. The was to encourage tidium, low fat, foods an or nutritionist had	view of al plan he . At the show				
d	BEACH SERVE	rovide adequate stat self-help dining pro	ff in cedures	S d	3502.11 Staff have been trained on a lining protocols to reflect so lining procedures		12/8/07
p to	his Statute is not me based on observation, ersons with Mental R o ensure self-help din rovided for each of th	the Group Home for etardation (GHMRP) ing procedures were) failed				
o	he finding includes: Deservation of the ding Administration	ner meal on Decemb	oer 5,				

STATE AND P	MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM	R/CLIA MBER:	(X2) M A. BUII B. WIN			E SURVEY IPLETED
NAME	OF PROVIDER OR SUPPLIER	HFD12-0054				1:	2/06/2007
					TY, STATE, ZIP CODE		200/2007
AZUI	₹E		1490 BAN WASHING	NGOR ST STON, DO	, SE : 20020		
(X4)	D SUMMARY STA	TEMENT OF DEFICIENCIES					
PREF	REGULATORY OR L	MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	Provider's Plan of C (Each Corrective active Cross-referenced to the Deficiency	ON SHOULD BE BE APPROPRIATE	(X5) COMPLETE DATE
10	53 Continued From pa	ge 3		1053			
	resident. At the time	ely 6:00 PM revealed pared a plate of food to of the survey, the Gi opportunity for each of ate in self-help dining	for each				
1 0:	57 3502.15 MEAL SER	VICE / DINING AREA	s	1 057	3502.15		1/12/08
	hinding a vallety of the	an on a weekly basis, oods at each meal, ar week and adjusted for	od bo	·	The nutritionist is in the precreating a new menu that revariation and adjustments to changes.	e flects	Ī
	This Statute is not m Based on observation review, the facility fail varied from week to v seasonal changes.	 interview, and recor ed to ensure menus y 	VOES !				
	The finding includes:						
	Dinner preparation ob 2007 at approximately facility's menus consistency. In an interview Coordinator on the afoacknowledged that the that were varied from the seasonal changes.	7 4:00 PM revealed that sted of three weeks of w with the Services prementioned date, it were presented to the presented t	vas				1/20/00
1 058	3502.16 MEAL SERVI	CE / DINING AREA		Į.	A new nutritionist was hired		1/12/08
-	A review and consultat nutritionist shall be con ensure that each reside prescribed a modified contrition according to hit to Administration	ion by a dietitian or ducted at least quarte ent who has been	erly to	r l n a	2/7/07 she completes a con eview of each residents reco 2/29/07 and will complete a ecessary annual and quarter ssessments for resident #1 a 2 and all residents in the ho	ord on the rly and resident	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	ER/CLIA MBER:	(X2) MULTI A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE: COMPL	ETED.
		HFD12-0054		<u> </u>		12/0	06/2007
NAME OF F	PROVIDER OR SUPPLIER		ľ	idress, city, 8 NGOR ST, SE	STATE, ZIP CODE		
AZURE				STON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
1 058	Continued From pa	ige 4		1058			
	Habilitation Plan.						
	Based on observation review, the GHMRF diets had been reviewed adequate in their needs for two consulting dietitian for received adequate in their needs for two consulting includes. The finding includes. The finding includes. Observation of Residents. The finding includes. Observation of Resident Nutritional Assessment According to the asserecommendation for loss/4 gram sodium. 1800 calorie diet /we Further review of Resident a nutritionist review of Resided to show eviden nutritionist had reviewed in the least quark According to Resident #2's record Assessment dated in from the assessment resident to eat low settime of the survey, the evidence that a dietitic record adequate the firming of the survey, the evidence that a dietitic record and the survey, the evidence that a dietitic record adequate in the survey, the evidence that a dietitic record adequate in the survey, the evidence that a dietitic record and the survey in the survey	ident #1 on December if the resident was over #1's record revealed went dated August 27 sessment Resident #1 r a 2000 calorie diet/ diet with a goal to re eight loss/4 gram soc esident #1's records re viewed his diet plan of the survey, the note that a dietitian or the wed Resident #1's re	eord dified dified dify by the esident de with die with die in the er 5, 2007 erweight. dia , 2007. dia dia diet. revealed on March GHMRP dodified pports view of al plan he At the show				
	quarterly.		3.0.4				
ealth Regular	tion Administration		1				

	OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	MBER;	A. BUILD B. WING			E SURVEY
NAME OF	PROVIDER OR SUPPLIER	HFD12-0054					
	CHANDER OK SUPPLIER				, STATE, ZIP CODE		2/06/200
AZURE		,	1490 BANG WASHING				
(X4) ID PREFIX TAG	TOTAL DELICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMA		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCE TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COM D/
1 082	Continued From pag	je 5		1 082	DEFICIENCY		_
1 082	3503.10 BEDROOM	IS AND BATHROOM			35 <u>03.10</u>		1 2 10 1
		is used by residents:	shall be		Cup dispensers have been	installed	1/1/
ļ	This Statute is not m Based on observation GHMRP failed to pro- with the appropriate in need.	is and interview the perly equip each bath	nroom sidents				
1	The findings include:						
t	During the environme December 6, 2007 be GHMRP was observe the bottom of their bat ime of the survey, the used.	ginning at 1:49 PM th d to have cup dispen- hroom sink, however	sers in		· <u></u>		.
1	504.1 HOUSEKEEPI		10	90 1.	004.1 Residents #1 closet wall	has been	12/15/
a	he interior and exterion in a safe, conditional in a safe, conditional sanitary manner as comulations of dirt, redors.	lean, orderly, attractived be free of	⁄e,	2.	The clothes rack in reside sident #5 room will be rep droom door has been repa	laced. The	1/5/08
fai	nis Statute is not met ased on observation a iled to ensure the inte aintained in a safe, cla nitary manner.	ind interview, the GH	. 1				
1 44			I I			i	

7.10	AN OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	BER:	A. BUILD B. WING		(X3) DAT	E SURVEY PLETED
NAMEO	F PROVIDER OR SUPPLIER	HFD12-0054		<u> </u>		1 12	2/06/200
					, STATE, ZIP CODE		00/ZOC
AZURI	E	1,	1490 BANG WASHINGT	OR ST, S	SE 20020		
(X4) ID	SUMMARY STA	TEMENT OF DESIGNATION					
PREFI) TAG	X CAUTI DEFICIENCY	MUST BE PRECEDED BY FUSC IDENTIFYING INFORMATI	JLL ON)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	LSHOULD BE	COM D
1 09	O Continued From pag	ge 6		090			
	During the environm	nental walk-through on Decipning at 2:46 PM #					
	The wall inside of #1's bedroom was so black marks.	fthe closet located in (piled and also observe	Client d with				
	bend due to the amor	nside of the closet loca t #5's bedroom had be unt of clothes hanging of their bedroom door t.	gan to				
l 161	3507.2 POLICIES AN	ID PROCEDURES	11		<u> </u>	_	12/20
	The manual shall be a body of the GHMRP a least annually.	approved by the govern and shall be reviewed a	ning at	D ev	he policy procedures have beviewed by the governing being the process will evidence of the review is planting of the review is planting of the process.	ody. The	12.20
	This Statute is not me Based on interview and GHMRP failed to proving governing body approve policies and procedure	d record review, the ide evidence that the yed and reviewed its			opies of the policy and proc	edures	
	The finding includes:					;	
	Interview with the Servi review of the policy and December 6, 2007 faile the manual had been re the governing body as r	d procedures manual or ed to provide evidence eviewed and approved	44 -4				
ľ	3509.3 PERSONNEL P	OLICIES	1 203	3		j	
	Each supervisor shall di			,			

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	OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	ABER:	A. BUILD B. WING		(X3) DATE COMP	SURVEY PLETED
NAME OF	PROVIDER OR SUPPLIER	HFD12-0054	070000			12/	06/2007
AZURE			1490 BAI	DDRESS, CITY NGOR ST, : GTON, DC	SE 20020		
(X4) ID PREFIX TAG	I CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F C IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPL DAT
I 206 3 E a c p w di	descriptions with each employment and at I	ch employee at the beeast annually thereafted as evidenced by: Indirect as evidenced by: Indirect as evidence that the vide evidence that the the contents of job in employee at the beand annually thereafted. P's personnel files on evealed the GHMRP filet three direct care sering job descriptions at the beginning of the innually thereafter. POLICIES To employment and all provide a physician the inventory has been employee is health at the perform the required as evidenced by: The GHMRP failed to yee, prior to employ in provided evidence of that documented and that the provided and that the permed	ginning er. ailed staff it is status ed	206 3: T m co	Job descriptions have bee and signed by the 3 direct not had current job descrifile. A monthly monitorin been put in place to ensure descriptions are current 509.6 The one direct care staff that issing their health certific completed it. A monthly means been in place to ensure extificates are kept current.	n completed staff who had ptions in their ng tool has e that job at was ate has onitoring health	1/1/08

	LAN OF CORRECTION	(X1) PROVIDER/SUPPLIE	MBER:	A. BUILE B. WING		(X3) DATE COMP	SURVEY PLETED
NAME	OF PROVIDER OR SUPPLIER	HFD12-0054		\perp		12	06/200
AZUR			STREET ADD	RESS, CIT	Y, STATE, ZIP CODE		00/200
			1490 BANG WASHING?	OR ST,	SE 20020		
(X4) I	D SUMMARY STA	TEMENT OF DEFICIENCIES	·				
PREF TAG	REGULATORY OR LS	MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	CHOLUR DE	COM
1 20	Continued From pag	je 8		206			┿
	The finding includes:			200			
	provide evidence that were on file for one d	lifect care staff,	C_ M				
1 22	3510.5(f) STAFF TRA	AINING	1	- 229 :	3510.5(<u>f</u>)		Ĺ
	Each training program	n nhalf iveles a second	- 1		Staff was trained on 12/13/07	7.1	12/1
	Each training program limited to, the followin	n susii iucinde' prit uc	ot be	ĭ	nutritionist on the resident's	by the	
		_	•	}	nome. In the fature the second	nets in the	
	(f) Specialty areas rela	ated to the GHMRP =	and the		nome. In the future the nutrit	ionist will	
	1	I IDCUICUA Britis Liter		ا د	rain staff at least annually or	when the	
	to, behavior managerr recreation, total comm technologies;	1001 coversión actuals.			liet needs of the residents cha	unge	
,	This Statute is not me Based on interview, ar GHMRP failed to ensur trained on each resider the three residents includes the sidents #1 and #2)	nd record review, the re staff were effective	ely .				
	The finding includes:						
	Interview with the direct 6, 2007 revealed that th with each of the residen	A 517# W 4 4	ber ar				
	Review of the training re 2007 revealed a nutritio conducted on October 1 was no documented evid modified diets were inclu	ecords on December on all training was 4, 2007, however, the					
	519.10 EMERGENCIES		ı	I		ľ	

STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION	E\$	(X1) PROVIDER/SUPPLI	ER/CLIA IMBER ;	(X2) MULT A. BUILDIN B. WING		(X3) DATE	SURVEY LETED
NAME OF PROVIDER OR SUP		HFD12-0054				12/	06/2007
AZURE	·		1490 BA	DDRESS, CITY, INGOR ST, SI IGTON, DC 2	STATE, ZIP CODE E 0020		<u> </u>
TOUCH CONTRACTOR	CIENCY	EMENT OF DEFICIENCIE MUST BE PRECEDED BY C IDENTIFYING INFORMA	s	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Health, Health unusual incide interferes with arrangement, places the resibe made by tel followed up by twenty-four (24) This Statute is Based on intervice GHMRP failed to Health, Health Fimmediately, followed and intervice of the five facility. (Resider The finding inclusion of the five facility.) Review of incide 2007 beginning a (allegation of negrequired: On August 23, 20 and Investigations incident report da (Department of Dinvestigator staff robserved to be lef Brookland Metro States.)	not meride resident and shall not merident and shall hours not meride a collities a collities and shall hours not meride end and shall hours not meride end and shall hours not meride end and shall hours not meride resident #5) and shall hours not meride resident #5) and shall hours not meride resident #5) and shall hours not meride resident report not shall hours	orting requirement in totify the Department is Division of any ovent which substant dent 's health, welfaing or in any other versions. Such notification within sor the next work distribution of the next work distribution was a possible of the Department of the Dep	of of their ially re, living vay on shall hall be ay. of n within alth, the coving ent	in He	Azure LLC was not awancident for resident until 2007. Azure LLC just rencident report on 1.2.08 and it has been faxed to f Health. The Department is been verbally notified accident. In the future who cident occurs the Department of the provided accident. In the surface and accident occurs the Department of the provided accident will be notified accident.	re of the I July 12, ceived the for resident # O Department ent of Health I of the en unusual	1/1/08

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AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLII IDENTIFICATION NU HFD12-0054	ER/CLIA I MBE R:	(X2) MUL A. BUILD B. WING		(X3) DATE COMP	SURVEY PLETED
NAME OF	PROVIDER OR SUPPLIER		STREET	ADDRESS OF	STATE, ZIP CODE	12	/06/2007
AZURE			1490 B	ANGOR ST, S	SF		
(X4) ID PREFIX TAG	I CAUM DEMICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	=	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULDE	(X5) COMPLET DATE
T ASSESSED	continued From page employed at the time allegation. An international date knowledge of the income and did not receive a until the latter part of the survey, the GHM evidence that the Dewas notified once the the allegation of negligible and the allegation of negligible and the survey. The GHMRP days to show evidence professional service for the threatening situation of the profession life threatening situation and immediately. This Statute is not mediately and the services for the finding includes: In interview was conducted the finding includes the finding to the survices coording to the survices coording to the survey, there are dampary. According to the survey, there are dampary there are of the survey, there are dampary the survey, there are dampary the survey, there are dampary the survey there are dampary the survey there are dampary.	e of the aforemention view with the CEO of the revealed the facility ident (allegation of recopy of the investig June 2007. At the take partment of Health expreceived the notific ect for Resident #5. ON SERVICES: GEN of a provide shall have fourteen the provide exprending a service, exceptions, arrangements at as evidenced by: when and record review ally Retarded Person (Residents #1 and #1) and #2 had received that the Services Coordinate of the provision of	n the had no neglect) had negle	1412 3 A 1 b	A new nutritionist was hired 2/7/07. In the future arrange e made for consultants immerithin 14 days based on the nate residents	ments will	12/7/07

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	MBER:	A. BUILDI		(X3) DATE COMF	SURVEY LETED
14145 05 4		HFD12-0054	FD12-0054 B. WING				10 a /a a a
NAME OF F	PROVIDER OR SUPPLIER	. "	STREET AL	DORESS, CITY,	STATE, ZIP CODE	1 12	<u>/06/200</u>
AZURE			1490 BA	NGOR ST, S STON, DC 2	E		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIE	s	ID	SPOURSE NO. 11		
PRÉFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY SCIDENTIFYING INFORMA	ET 14 1	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMI DA
1 412	Continued From pa			1412			-
	evidence that an an the aforementioned	rangement had been professional service.	made for	<u> </u>		·	
1 436	3521.7(f) HABILITA	TION AND TRAINING	G	1436 3	<u> </u>		171/0
			i		f) IPP's have been revised	l fo-	1
í	The habilitation and training of residents GHMRP shall include, when appropriate be limited to, the following areas:		by the	r	esident#1 to include a pro	110r	ł
			put not	Se	ell-medication. In the figh	ire all areas	
				O.	I possible training will be	reviewed	1
)	(I) Héalth care (inclu-	ding skills related to	nutrition,	ái	nd included in the resident	rs ISP	
i i	age our geh-gaminis	tration of medication prostnetic and orthotic	firet			D 101.	1
	devices, preventive h	nealth care, and safet	ν).				
!			971	1	•		
į	This Statute is not m	et as evidenced by: n, interview and reco	. 1				
, ,	eview, the GHMRP t	Blied to ensure the					
r	labilitation and trainir	od of its residents in t	he area			 	
· c	of self-medication add	ministration.					
Ţ	he finding includes:						
; c	Observation of the evidence of	ening medication	}				
	urumstration on Dec	2006er6 2007 at 6.4	6 PM		·		
1.6	vealed Resident #1	received modioations	· ~ [
de	ownstairs independe	to bring a glass of w	vater		·	1	
[" ,	TO URISE MAS ODSELV	'ed to remove the rec	أحاد حادة				
(111	carration from the Pi	UDDIE Dack and hand	tha				
1 111	edications to the resi	ident.Residont#4	!				
j 84	אז זמת מום מושטופיים י	ame of his medication spond, but just looke	لتنس			į	
1 44 14	FINEQUOAVON, INP. III	Urse said the name -	اعادك			1	
1 ,,,,,	earcamon and the les	ildent feneated it. 🗛	than I				
l an	ie of the survey, ther idence that self-med	色 いうに ひへ べっさいきょうしゃ	ed			ĺ	
. 1170	いっちゅう III 以ら2106Uf 集J	ication training was I's Individual Habilitat	ion			ĺ	
Pla	an (IHP).						
- 1	Administration		ı	1		ļ	

AND FEAT	OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMI	BER:	A. BUILD		(X3) DATE COMP	SURVE
NAME OF	PROVIDER OR SUPPLIER	HFD12-0054		B. WING		120	ne/na
	PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY	STATE ZIP CODE		06/20
AZURE			1490 BANGO WASHINGTO	DR ST, : DN, DÇ	SE 20020		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		ID	PROVEDENCE DE LA CALLANTE		,
TAG	REGULATORY OR LS	MUST BE PRECEDED BY FL C IDENTIFYING INFORMATION	ON)	PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	タリハル ちゃこ	CON
I 442	Continued From pag	je 12		442		·	<u> </u>
		TION AND TRAINING		.=	$\frac{1}{3521.7}$ — — —	·	J
	· · · · · · · · · · · · · · · · · · ·	TON AND TRAINING	14	T-T-Z			1/1/1
	The habilitation and	training of residents by	, the		(1) IPP's have been revised i	or residents	1
!	CHAINE SHAIL INCING	3. When appropriate is	ute		#1 and residents #2 to inclu	de	
	be limited to, the folio	wing areas:	4,1100		programs to address the fina	ncial need	İ
					of the residents. In the future	all areas	1
	(I) Time managemen	t (including use of leis	ure		of possible training will be re	viewed	}
!	time, scheduling activ	/ities);	ĺ	á	and included in the residents	ICD	
į	This Statute is not -		i			151	
	This Statute is not m	et as evidenced by: nd record review, the f					
1	failed to ensure the ci	ients' right to be taugh	acility				
1.	manage their financia	lents right to be taugh I affairs to the extent of	it to	ļ			
	capabilities for two of	the three clients in the	of their				
(*	sample.		•	- 1		1	
((Residents #1 and #2))					
1	The findings include:					·	
J	nterview with the Serv	ices Coordinator on					
4-	Jecember 6, 2007 at a	BDDroximately 1-45 DM	1	- 1			
,	chegica migrikisidebi	'#1 20d #2 had est		1			
110	eceived a comprehen	SÍVA MODAY MARAGA	ent				
; •	aacaament (USt Offill)	ed his current etille as	nd			[
	Perille needs in this a	Tea Review of the	l l	1		ĺ	
P	esidente #1 and #0 =	entioned date revealed	1				
P	esidents #1 and #2 had lans (ISP) dated March	ad individual Support		- 1		1	
5.	2007 respectively. F	th 22, 2007 and Febru	ary			1	
56	ection of the ISP entitle	utuler review of the		.		į	
ге	vealed that the cliente	ed Decision Making did not show capacity	. 1				
;	gerung inances at:	the time of the current	/				
1 0 10	cie was no document	ed evidence that	ľ			1	
176	Sidents #1 and #2 wa	is faught to manage #	neir	1.		1	
fin	ances to the extent of	their capability.	.511				
1 444 35	21.7(n) HABILITATIO	N AND TRAINING	1 444				
The	e habilitation and train	ing of residents by the					
	······································	ting of residents by the hen appropriate, but n	9				
	Administration	・・・・・ ロレレーレンバイバタ カーバーカ	73T				

AND FLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM	R/CLIA MBER:	A. BUILDI		(X3) DATE COMP	
NAME OF	000 000 000 000 000 000 000 000 000 00	HFD12-0054		B. WING		12/	06/2007
	PROVIDER OR SUPPLIER				STATE, ZIP CODE		<u> </u>
AZURE			WASHING	GOR ST, S TON, DC	E 20020		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	-111)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	COMPI
t (be limited to, the formula of the limited to, the formula of attempts of attem	llowing areas: pre-academic skills (incention span, discriminary, and number, time, and record review, the sure habilitation and the area of academic and academic and area of academic and academic and area of academic and academic skills to increase academic skills t	ation, and sand sand sand sand sand sand sand	; ;	3531.7 (n) IPP's have been revise #1 to include a program academic needs. In the fut of possible training will be and included in the resider	ed for resident ddressing ture all areas e reviewed	1/1/0